Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TEXAS 77504

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-08-0068-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated August 23, 2007: "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges. In addition, the Carrier applied the incorrect reimbursement methodology to Vista's charges." "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules." "In this instance, the audited charges that remained in dispute after the last bill review by the insurance Carrier **$141,829.74**...The Carrier made a partial payment of **$18,098.60**. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation reimbursement amount of **$85,254.96,** plus any and all interest applicable."

Requestor's Supplemental Position Summary Dated October 28, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment…The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least two reasons…The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons…"

Amount in Dispute: $85,254.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated September 21, 2007: "The Requestor asserts it is entitled to reimbursement in the amount of $106,372.30, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement…"

Responses Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 11, 2007 through April 14, 2007	Inpatient Hospital Services	$85,254.96	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027(e), requires the insurance carrier to "…sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee".
2. 28 Texas Administrative Code §133.240(e) effective May 2, 2006, 31 TexReg 3544, states, in pertinent part, that "The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division..."
3. Former 28 Texas Administrative Code §133.305, effective December 31, 2006, 31 TexReg 10314, sets out general provisions for medical dispute resolution.
4. Former 28 Texas Administrative Code §133.307, effective December 31, 2006, 31 Texas Register 10314, applicable to disputes filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
5. Former 28 Texas Administrative Code §134.401, 22 Texas Register 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
6. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 Texas Register 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
7. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 19, 2007
   - 226-Included in global charge.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 97-Payment is included in the allowance for another service/procedure.
   - W1-Workers compensation state fee schedule adjustment.
   - Precerted and paid for 2 IP surgical days. Implants at cost plus 10 percent, and blood at f&r.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

Division rule at 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 Texas Register 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a

position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Austin's Third Court of Appeals November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." On August 10, 2011, both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The Division did not receive supplemental information from the respondent and received supplemental information from the requestor on October 28, 2011. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Austin's Third Court of Appeals November 13, 2008 opinion, the Division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services in this case are unusually extensive; and whether the admission and disputed services in this case are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c) (6) puts forth the requirements to meet those three factors.

1. The requestor in its position statement asserts that "The Carrier did not make a legal denial of reimbursement because Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges. In addition, the Carrier applied the incorrect reimbursement methodology to Vista's charges." Texas Labor Code §408.027(e), requires the insurance carrier to "…sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee". 28 Texas Administrative Code §133.240(e) effective May 2, 2006, 31 TexReg 3544, states, that "The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division..." Review of the submitted documentation finds that the explanation of benefits dated June 19, 2007 was issued using the division-approved form TWCC 62 and noted payment exception codes "226-Included in global charge"; "790-This charge was reimbursed in accordance to the Texas medical fee guideline"; "97-Payment is included in the allowance for another service/procedure"; "W1-Workers compensation state fee schedule adjustment"; and "Precerted and paid for 2 IP surgical days. Implants at cost plus 10 percent, and blood at f&r". These payment exception codes support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401, and therefore support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount. The Division finds that the explanation of benefits was sent in the prescribed form and manner as required by Division instructions. The Division further finds that the explanation of benefits provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has met the requirements of Texas Labor Code §408.027(e), and 28 Texas Administrative Code §133.240(e).

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold.." Furthermore, (A) (v) of that same section states "…Audited charges are those which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier on June 19, 2007 finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v), therefore the audited charges equal $141,829.74. The Division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement stated, in pertinent part "…if the total audited charges for *the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission'." As noted above, the Austin Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement dated October 28, 2011 the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an

admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

> "The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least two reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestors position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the Division finds that the requestor failed to demonstrate that the admission and services in dispute are unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

   > "The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries."

   The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries, and therefore fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in "other types of surgeries." As noted above, the Third Court of Appeals November 13, 2008 opinion stated that "…the Stop-Loss Exception was meant to apply on a case-by-case basis in a relatively few cases." The Division concludes that the requestor failed to demonstrate that the specific services in this dispute were unusually costly when compared to similar spinal surgery services or admissions.

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, 28 Texas Administrative Code §134.401(c) (1) applies. Review of the

submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "(ii) The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" In addition to the per diem amount, 28 Texas Administrative Code §134.401(c)(4), allows for additional reimbursement for certain items. This additional reimbursement applies only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section. The length of stay is 3 days. The respondent paid for two inpatient surgical days based upon "Precerted and paid for 2 IP surgical days. Implants at cost plus 10 percent, and blood at f&r"; "790-This charge was reimbursed in accordance to the Texas medical fee guideline"; and "W1-Workers compensation state fee schedule adjustment". The surgical per diem rate of $1,118 multiplied by the preauthorized length of stay of 2 days results in an allowable amount of $2,236.00.

28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." A review of the submitted hospital bill finds that the requestor billed $52,300.00 for revenue code 278-Implants. A review of the submitted EOB indicates that the respondent paid $15,241.60 based upon reason codes "Precerted and paid for 2 IP surgical days. Implants at cost plus 10 percent, and blood at f&r"; "790-This charge was reimbursed in accordance to the Texas medical fee guideline"; and "W1-Workers compensation state fee schedule adjustment".

The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
Anterior Implant	1	$5000.00	$5000.00 + $500.00 = $5500.00
Screw Incompass	2	$1350.00/each	$1350.00 + $135.00 = $1485.00 X 2 = $2970.00
Screw Incompass	2	$1350.00/each	$1350.00 + $135.00 = $1485.00 X 2 = $2970.00
Closure Tops	4	$210.00/each	$210.00 + $21.00 = $231.00 X 4 = $924.00
Rod Prebent	2	$575.00	$575.00 + $57.50 = $632.50 X 2 =$1265.00
TOTAL DUE			$13,629.00

28 Texas Administrative Code §134.401(c)(4)(B), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $828.00 for revenue code 380-Blood-General. The respondent reimbursed the requester $621.00 for revenue code 380 based upon "Precerted and paid for 2 IP surgical days. Implants at cost plus 10 percent, and blood at f&r"; "790-This charge was reimbursed in accordance to the Texas medical fee guideline"; and "W1-Workers compensation state fee schedule adjustment". The requestor is not disputing the amount of reimbursement for this service.

Based upon the per diem reimbursement methodology and submitted documentation, the total allowable is $16,486.00. Review of the submitted documentation finds that the respondent issued payment in the amount of $18,098.60 ($2236.00 + $15241.60 + 621.00) for the surgical days, implants and blood. No additional amount is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually costly services, and failed to demonstrate that the services in dispute were unusually extensive. The requestor further failed to establish that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		3/30/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		3/30/2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.